U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 23May2002

Case No: 1999-BLA-1180

In the Matter of

CLARENCE E. BROWN,
Claimant

v.

DOMINION COAL CORPORATION,
Self- Insured Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:

Clarence E. Brown
Pro se

Ronald E. Gilbertson, Esquire
For the employer/carrier

BEFORE: JOSEPH E. KANE
Administrative Law Judge

DECISION AND ORDER ON REMAND — DENYING BENEFITS

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq.* (the Act). Benefits are awarded to coal miners who are totally disabled due to pneumoconiosis.

Surviving dependents of coal miners whose deaths were caused by pneumoconiosis may also recover benefits. Pneumoconiosis, commonly known as black lung, is a chronic dust disease of the lungs arising from coal mine employment. 20 C.F.R. § 718.201(a) (2001).

On July 27, 1999, this case was referred to the Office of Administrative Law Judges for a formal hearing. Following proper notice to all parties, a hearing was held on April 13, 2000, in Abingdon, Virginia. I denied the claim in a July 26, 2000 Decision and Order. Claimant appealed my denial, and, on August 29, 2001, the Benefits Review Board affirmed in part and vacated in part my denial. The Benefits Review Board remanded the instant case to me to readdress the vacated portion of my previous decision.

The Findings of Fact and Conclusions of Law that follow are based upon my analysis of the entire record, arguments of the parties, and the applicable regulations, statutes, and case law. They also are based upon my observation of the demeanor of the witnesses who testified at the hearing. Although perhaps not specifically mentioned in this decision, each exhibit and argument of the parties has been carefully reviewed and thoughtfully considered. While the contents of certain medical evidence may appear inconsistent with the conclusions reached herein, the appraisal of such evidence has been conducted in conformance with the quality standards of the regulations.

The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title. References to DX, CX, and EX refer to the exhibits of the Director, claimant, and employer, respectively. The transcript of the hearing is cited as "Tr." and by page number.

ISSUE

The sole issue remaining on remand is whether the newly submitted evidence establishes complicated pneumoconiosis and, concomitantly, a material change in conditions within the meaning of Section 725.309(d).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and Procedural History

The claimant, Clarence E. Brown, was fifty-five years old at the time of the hearing and has a seventh grade education. (Tr. 12; DX 1). He has one dependent, his wife, for purposes of augmentation of benefits. (Tr. 23; DX 1, 7). The claimant quit smoking close to twenty years ago. (Tr. 24).

The claimant filed his first claim for benefits under the Act on July 13, 1992. It was denied by the District Director, Office of Workers' Compensation Programs ("OWCP") on March 4, 1993. The OWCP found that the claimant had been a coal miner for at least 17.5

years and that he had coal workers' pneumoconiosis which arose from his coal mine employment. However, as the OWCP did not find total disability, benefits were denied. The claimant did not appeal that denial. (DX 29).

The claimant filed a second claim on May 25, 1994. After a formal hearing, Administrative Law Judge Jeffrey Tureck denied the claim on June 28, 1996. Judge Tureck found that the claimant had been a coal miner for twenty-eight years, and that Dominion Coal was the responsible operator. However, he did not find a material change in conditions as the newly submitted pulmonary function and arterial blood gas tests revealed normal values, and he found the weight of the evidence negative for complicated pneumoconiosis.

The claimant appealed the denial to the Benefits Review Board ("the Board"). However, after the claimant failed to respond to the Board's Order to Show Cause, the Board dismissed the appeal as abandoned on April 16, 1997. (DX 30).

The claimant filed the instant claim on October 15, 1998. (DX 1). The employer was notified of the claim, and subsequently controverted based on both the claimant's eligibility and the employer's liability. (DX 19, 20, 22). The OWCP awarded benefits on May 26, 1999 based on a finding of complicated pneumoconiosis. (DX 26). As the employer declined to voluntarily commence the payment of benefits, benefits have been paid by the Black Lung Disability Trust Fund retroactive to May 1, 1999. (DX 28). The employer requested a formal hearing, and the claim was referred to the Office of Administrative Law Judges ("OALJ") on July 27, 1999. (DX 27, 32). I denied the claim on July 26, 2000.

Claimant appealed my denial, and, on August 29, 2001, the Board affirmed in part and vacated in part my denial.[1] The instant case comes before me a second time to address the narrow question of whether the newly submitted medical evidence demonstrates, by a preponderance of the evidence, the presence of complicated pneumoconiosis. If the evidence demonstrates complicated pneumoconiosis, the claimant will have met his burden of demonstrating a material change in condition, and a complete review of the evidentiary record will follow to determine the claimant's entitlements to benefits.

[1] The Board affirmed my determination that the newly submitted evidence did not establish, by a preponderance of the evidence, total disability pursuant to 20 C.F.R. §718.204(c)(2000).

Medical Evidence[2]

A. X-ray Reports

Exhibit	Date of X-ray	Film Qual.	Physician/ Qualifications[3]	Interpretation.
DX 25	11/2/93	1	Alexander/B, BCR	2/2, p/q, 6 zones; ax; large opacity, A. Pleural thickening (pi).
EX 1, EX 2	11/2/93	1	Wheeler/BCR, B	Nodular infiltrate right apex and subapical portion RUL more than left apex and subapical portion LUL with small calcified granulomata also involving pleura compatible with TB unknown activity with 4-5 cm mass in lateral right apex compatible with conglomerate TB. Healed anterior chest surgery for coronary artery bypass. Possible minimal emphysema/ check PFTs.

[2] The medical evidence as summarized in the July 26, 2000 Decision and Order, to the extent not discussed herein, is incorporated by reference into this Decision and Order on Remand.

[3] The symbol "BCR" denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc. or the American Osteopathic Association. 20 C.F.R. § 727.206(b)(2).

The symbol "B" denotes a physician who was an approved "B-reader" at the time of the x-ray reading. A B-reader is a physician who has demonstrated expertise in assessing and classifying x-ray evidence of pneumoconiosis. These physicians have been approved as proficient readers by the National Institute of Occupational Safety & Health, U.S. Public Health Service pursuant to 42 C.F.R. § 37.51 (1982).

Exhibit	Date of X-ray	Film Qual.	Physician/ Qualifications	Interpretation.
EX 3, EX 4	11/2/93	1	Scott/BCR, B	Nodular scarring/infiltrates with calcified granulomata right apex more than left apex compatible with healed Tb. Anterior chest surgery (Co).
EX 1	5/5/94	1	Wheeler/BCR, B	Nodular infiltrate. Oval 5 cm mass. Tb. Co. Possible em.
EX 3	5/5/94	1	Scott/BCR, B	Peripheral scarring apical with calcified granulomata compatible with healed Tb. Co.
DX 25	5/2/95	2	Alexander/B, BCR	Complicated pneumoconiosis, category A, p/q, 2/2, ax, pi.
DX 25	4/30/96	1	Alexander/B, BCR	Complicated pneumoconiosis, category B, p/q, 2/2 ax, pi.
DX 24	4/30/96	n/a	Smiddy	Severe complicated bilateral pneumoconiosis. Cannot rule out occult concomitant process.
EX 1	4/30/96	2	Wheeler/BCR, B	Nodular infiltrate. Oval 5 cm mass. Tb. Co. Possible em.
EX 3	4/30/96	1	Scott/BCR, B	Apical peripheral scarring with calcified granulomata compatible with healed Tb. Co.

Exhibit	Date of X-ray	Film Qual.	Physician/ Qualifications	Interpretation.
EX 1	9/17/96	2	Wheeler/BCR, B	Nodular infiltrate. Oval 3 x 4.5 cm mass. Tb. Co. Possible em.
EX 3	9/17/96	2	Scott/BCR, B	Apical scarring and calcified granulomata R > L compatible with healed Tb. Co.
EX 1	1/7/97	2	Wheeler/BCR, B	Nodular infiltrate. Oval 3 x 4.5 cm mass. Tb. Co. Possible em.
EX 3	1/7/97	1	Scott/BCR, B	Scarring periphery both apices R > L, and calcified granulomata all probably due to healed Tb. Co.
DX 24	1/7/97	-	Smiddy	Severe complicated bilateral pneumoconiosis. No definite change since prior film.
DX 25	9/8/97	1	Alexander/B, BCR	Complicated pneumoconiosis, category B, p/q, 2/2 ax, pi.
EX 1	9/8/97	2	Wheeler/BCR, B	Nodular infiltrate. Oval 3 x 4.5-5 cm mass. Tb. Co. Possible em.
EX 3	9/8/97	2	Scott/BCR, B	Scarring both apices, R > L and calcified granulomata all probably due to healed Tb. Co.

Exhibit	Date of X-ray	Film Qual.	Physician/ Qualifications	Interpretation.
DX 24	9/8/97	-	Smiddy	Extensive old changes of bilateral pneumoconiosis. There is some waxing and waning in difference in visulazation of various densities in part due to x-ray change, but cannot definitely rule-out an active process. All serial films were again reviewed.
EX 1	3/10/98	2	Wheeler/BCR, B	Nodular infiltrate. Oval 3 x 4.5 cm mass. Tb. Co. Possible em.
EX 3	3/10/98	1	Scott/BCR, B	Peripheral scarring both apices R > L, and calcified granulomata all probably due to healed Tb. Co.
CX 5, DX 24	3/10/98	-	Smiddy	Extensive changes of bilateral pneumoconiosis.
DX 25	9/10/98	1	Alexander/B, BCR	Complicated pneumoconiosis, category B, p/q, 2/2, ax, pi.
EX 1	9/10/98	2	Wheeler/BCR, B	Nodular infiltrate. Oval 3 x 4.5 cm mass. Tb. Co. Possible em.
EX 3	9/10/98	1	Scott/BCR, B	Peripheral scarring both apices, R > L, and calcified granulomata all probably due to healed Tb.Co.

Exhibit	Date of X-ray	Film Qual.	Physician/ Qualifications	Interpretation.
CX 6, DX 24, DX 13	9/10/98	-	Smiddy	Extensive changes of bi-pneumoconiosis, stable.
DX 14	11/6/98	1	Forehand/B	Bilateral apical scarring Tb.
DX 16	11/6/98	1	Duncan/BCR, B	1/1, r/r, upper zones; ax; large opacity, A.
DX 15	11/6/98	1	Cole/BCR, B	1/1, q/r, upper and mid zones. Cancer (ca). Co. Tb. Mass lesion right apex, etiology not determined - tb to be excluded.
DX 17	11/6/98	1	Navani/BCR, B	1/1, q/r, 6 zones; ax; large opacity, A. Em. Tb. Previous cardiac surgery.
CX 1	11/6/98	1	Alexander/BCR, B	2/2, p/q, upper and mid zones; ax. Large opacity, B. Pleural thickening. Pi.
EX 5	11/6/98	1	Wheeler/BCR, B	Nodular infiltrate. Lobulated 3 x 4.5 cm mass. Tb. Co.
EX 6	11/6/98	1	Scott/BCR, B	Nodular apical infiltrates/ fibrosis, R > L, compatible with Tb, unknown activity. 4 x 3 cm mass right apex, probable granulomatous mass due to Tb, cannot entirely rule out cancer. Co.
DX 25	3/9/99	1	Alexander/B, BCR	Complicated pneumoconiosis, category B, p/q, 2/2, ax, pi.

Exhibit	Date of X-ray	Film Qual.	Physician/ Qualifications	Interpretation.
EX 1	3/9/99	2	Wheeler/BCR, B	Nodular infiltrate. Oval 3 x 4.5 cm mass. Tb. Co. Possible em.
EX 3	3/9/99	1	Scott/BCR, B	Peripheral scarring apices, R > L, and calcified granulomata, all probably due to healed Tb. Co.
EX 8	10/28/99	1	Castle/B	1/1, r/q, upper zones. Large opacity A. Previous chest surgery. Changes could be due to granulomatous disease but are compatible with large opacity.
CX 15	3/7/00	1	DePonte/BCR, B	1/1, q/p, 6 zones; ax; Large opacities, A.
CX 4	3/13/00	1	Robinette/B	2/1, q/r, 6 zones; ax; Large opacity, A. Emphysema S/P median sternotomy with CABG.
CX 8	3/13/00	-	Mullens	Previous CABG. Nodular interstitial lung disease with right apical mass consistent with silicosis/CWP and progressive massive fibrosis.

B. Medical Opinions

Dr. Joseph F. Smiddy is the claimant's treating physician. He examined the claimant in follow-up on March 10, 1998 and September 10, 1998. (CX 5, 6). On March 9, 1999, Dr. Smiddy wrote to the claimant that:

> We have compared all of your x-rays from 11-02-1993 through 03-90-1999. Your x-rays show bilateral upper lobe densities greater on the right consistent with progressive massive fibrosis

> secondary to complicated pneumoconiosis. We believe that you are disabled by your complicated pneumoconiosis.
>
> I am aware that several years ago other physicians diagnosed you to have other diseases, however, there is no evidence of any disease other than pneumoconiosis. In 1996 we specifically bronchoscoped you and found no evidence of tuberculosis or cancer and your x-ray has not changed since that time confirming that no tuberculosis or cancer is present.

(DX 24; CX 9). Dr. Smiddy is board-certified in internal medicine and board-eligible in pulmonary medicine. (CX 11).

Dr. German Iosif examined the claimant on November 6, 1998. He reviewed the claimant's histories, symptoms and medications. He also reviewed his previous examination findings from June 1994. Examination of the chest was normal. A pulmonary function study was normal, as was an arterial blood gas test. An x-ray was read by Dr. Forehand as showing bilateral apical scarring suggestive of prior tuberculosis infection, sternal wires and surgical clips from prior CABG surgery. Dr. Iosif found no evidence of respiratory functional impairment. As to the x-ray findings, he stated that:

> The chest x-ray is interpreted as showing old or healed granulomatous disease, possibly tuberculosis. The claimant does not recall having had such diagnosis or condition before and his PPD skin reactivity status is unknown. I would suggest additional B-reader interpretations of this film and comparison with those from 1994 in order to see if the upper lobe findings could correspond to simple and/or complicated coal workers' pneumoconiosis. The diagnosis of bronchogenic carcinoma cannot be supported in view of the apparent stability or lack of progression in the above-mentioned radiological abnormalities.

Dr. Iosif is board-certified in internal and pulmonary medicine. (DX 9).

Dr. John A. Michos reviewed medical records on behalf of the OWCP and issued a report on February 25, 1999. He concluded that:

> Mr. Brown has established a diagnosis of CWP based on a 26 year history of CME which ended in 1991.
>
> As to the issue of whether the lesion in the right upper lobe represents a lesion from old tuberculosis or complicated CWP, it would be my reasoned opinion that complicated CWP or

> silicotuberculosis has not conclusively been excluded. However, the miner at present would quality for benefits, based on his prior CME history and radiologic abnormalities.

Dr. Michos is also board-certified in internal and pulmonary medicine. (DX 11).

Dr. Michael S. Alexander reviewed a series of ten x-rays, including the six readings listed above, on April 3, 1999. After indicating specific changes from x-ray to x-ray, Dr. Alexander concluded that:

> This series of chest x-rays spanning the time period from 11/02/93 through 03/09/99 demonstrates classical features of complicated Coal Worker's Pneumoconiosis, with slow but progressive coalescence of small opacities into large opacities particularly in the right upper zone. Pertinent negative findings include: No significant emphysema or bullae. No superimposed pulmonary infection or pleural effusions. No evidence of active or healed tuberculosis.

(DX 25).

Dr. James R. Castle examined the claimant on October 28, 1999 on behalf of the employer. He reviewed the claimant's histories, symptoms, and medications. Examination of the lungs was normal. An x-ray was read as positive for changes consistent with pneumoconiosis, 1/1, A, but "all of these changes could be due to granulomatous disease as well." A pulmonary function study and an arterial blood gas test were both normal. An electrocardiogram was obtained. Dr. Castle diagnosed radiographic evidence of simple coal workers' pneumoconiosis, r/q, 1/1; radiographic evidence consistent with but not diagnostic of complicated pneumoconiosis category A; no respiratory impairment from any cause; coronary artery disease; and angina pectoris. He concluded that:

> It is my opinion that the changes on the chest x-ray of a large opacity could be due to granulomatous disease. It is not possible for me to accurately determine whether or not these changes are granulomatous or are due to a large opacity of coal workers' pneumoconiosis. Nevertheless, they are consistent with coal workers' pneumoconiosis.

(EX 8).

Dr. Branscomb issued a supplemental report on November 3, 1999 after reviewing additional records. His opinion remained the same. (EX 7).

Dr. Emory H. Robinette, Jr. examined the claimant on March 13, 2000. He reviewed the claimant's histories, symptoms, and medications. An x-ray was positive for pneumoconiosis, 2/1, q/r with axillary coalescence and a category A mass in the right upper lobe. The x-ray also showed evidence of a previous mediastinotomy with apparent CABG, distortion of the pulmonary parenchyma, and emphysematous change. A pulmonary function study and an arterial blood gas test were normal. Dr. Robinette also obtained a comprehensive metabolic profile and a resting EKG. His impression was complicated coal workers' pneumoconiosis; ASCVD, status post coronary bypass surgery; hyperlipidemia; and history of benign prostatic hypertrophy. Dr. Robinette concluded that:

> At the time of my evaluation Mr. Brown related a history of work- ing in the mining industry a total of 28 years. He last worked in 1990. His medical history was complicated by a prior pulmonary evaluation by Dr. Joe Smiddy because of an abnormal chest x-ray with a prior bronchoscopy and transbronchial biopsies. PPDs have been checked and have all been negative. Records were requested from Dr. Smiddy's office. The records included Dr. Smiddy's letter to Mr. Brown which documented that the x-rays had been compared from 1993 through 1999 with x-rays showing evidence of bilateral upper lobe densities, right greater than the left consistent with a diagnosis of progressive massive fibrosis and coal workers' pneumoconiosis. Because of the prior bronchoscopy Dr. Smiddy felt that there was no evidence of cancer or malignancy and that his clinical syndrome was felt to be consistent with complicated coal workers' pneumoconiosis.
>
> It is my medical opinion that Mr. Brown has evidence of complicated coal workers' pneumoconiosis and is disabled from working in a dusty environment on the basis of his radiographic abnormalities which are well documented. Although there is no evidence of functional impairment he has significant scar and distortion of his pulmonary parenchyma. This condition is chronic and irreversible and directly related to his prior coal mining employment. He is a candidate for a year flu vaccine and should take pneumococcal vaccines every 5 to 10 years.

(CX 7). Dr. Robinette is board-certified in internal and pulmonary medicine. (CX 11).

Dr. Wheeler was deposed on March 21, 2000. He opined that "the high location, the asymmetry, the disease all put it outside of the central lung zones where I'd expect to see silicosis and coal workers pneumoconiosis." The negative tuberculosis tests did not change

his mind, because the PPD skin test is useful in revealing active cases of tuberculosis, but not healed tuberculosis. Dr. Wheeler further opined that the changes on the x-rays remained stable from January 7, 1997 to March 1999. (EX 9).

Dr. Branscomb was deposed on March 29, 2000. He explained that while he did not find that the claimant had pneumoconiosis, he has assumed that he has simple coal workers' pneumoconiosis based on the findings of others. He made this assumption in order to address the larger issue: whether the mass is complicated coal workers' pneumoconiosis or some other process. Dr. Branscomb stated that the location and appearance of the opacities was atypical for coal workers' pneumoconiosis. He explained that:

> [T]he high up and back part of the lung, which is where this man's disease is, is an area that's so poorly ventilated it's thought that is the explanation for why it is the primary site for tuberculosis because the TB organism has a good shock there without having a lot of oxygen put in on top of it.

Although he did not diagnose the condition, Dr. Branscomb explained that:

> [S]ilicotuberculosis is a term used when tuberculosis and silicosis are occurring in the same part of the lung at the same time. It is thought that the lung is more vulnerable to TB by virtue of the presence of the silicosis and that the silicosis and the TB produce more scarring by virtue of the combination of these two diseases.

The most recent x-ray he reviewed was from 1995. (EX 10).

DISCUSSION AND APPLICABLE LAW

Because Mr. Brown filed his application for benefits after March 31, 1980, this claim shall be adjudicated under the regulations at 20 C.F.R. Part 718. Under this part of the regulations, claimant must establish by a preponderance of the evidence that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, that he is totally disabled, and that his total disability is due to pneumoconiosis. Failure to establish any of these elements precludes entitlement to benefits. *See Anderson v. Valley Camp of Utah, Inc.*, 12 BLR 1-111, 1-112 (1989). Furthermore, because the instant claim was brought more than one year after a previous denial, the claimant must establish a material change in condition before his claim can be considered on the merits. 20 C.F.R. § 725.309(d). To establish a material change in condition, claimant must establish the presence of complicated pneumoconiosis, as the Board affirmed my previous determination that the newly submitted evidence did not demonstrate total disability.

The United States circuit courts of appeals have developed divergent standards to determine whether "a material change in conditions" has occurred. Because Mr. Brown last worked as a coal miner in the state of Virginia, the law as interpreted by the United States Court of Appeals for the Fourth Circuit applies to this claim. *Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989).

Under the Fourth Circuit's standard for determining the existence of a material change in conditions, an administrative law judge must consider all of the new evidence, both favorable and unfavorable, to determine whether the miner has proven at least one of the elements of entitlement that previously was adjudicated against him. If a claimant establishes the existence of one of these elements, he will have demonstrated a material change in condition as a matter of law. Then, the administrative law judge must consider whether all the evidence of record, including evidence submitted with the prior claims, supports a finding of entitlement to benefits. *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358, 1363 (4th Cir. 1996). *See Sharondale Corp. v. Ross*, 42 F. 3d 993, 997-98 (6th Cir. 1994).

The relevant newly submitted evidence to a determination of complicated pneumoconiosis consists of x-ray interpretations and narrative medical opinions. Each shall be addressed separately.

The record contains seventeen x-ray interpretations diagnosing tuberculosis, eleven x-ray interpretations diagnosing complicated pneumoconiosis, and six x-ray interpretations diagnosing simple pneumoconiosis.

Because pneumoconiosis is a progressive disease, I may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. I also may assign heightened weight to the interpretations by physicians with superior radiological qualifications. *See McMath v. Director, OWCP*, 12 BLR 1-6 (1988); *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989) (en banc).

Three physicians - Drs. Wheeler, Scott, and Forehand - interpreted the mass in Claimant's lungs as healed tuberculosis. Six physicians - Drs. Alexander, Smiddy, Castle, DePonte, Mullens, and Robinnette - interpreted the mass to represent complicated pneumoconiosis. Four physicians - Drs. Smiddy, Duncan, Cole, and Navani - produced interpretations concluding that Claimant's lung mass represented simple pneumoconiosis. Drs. Navani and Cole also included in their interpretations that tuberculosis was present.

I accord Dr. Smiddy's interpretations little probative weight as the doctor offered consecutive x-ray interpretations exhibiting impossible results. Dr. Smiddy's first two x-ray interpretations, produced on March 30, 1996, and January 7, 1997, diagnosed complicated pneumoconiosis. Dr. Smiddy's subsequent x-ray interpretations, however, diagnosed bilateral pneumoconiosis, not complicated pneumoconiosis. Pneumoconiosis is a progressive disease,

not a regressive disease. Consequently, I accord little weight to Dr. Smiddy's x-ray interpretations.

The remaining physicians produce plausible interpretations entitled to probative weight. I accord more probative value, however, to the interpretations of Drs. Wheeler, Scott, Alexander, Duncan, Cole, Navani, and DePonte as those physicians are dually-qualified physicians. I grant some additional weight to the opinions of Drs. Robinette, Castle, and Forehand as each is a "B" reader. I accord more weight to the interpretation of a dually-qualified physician as compared to only a "B" reader as the Benefits Review Board has held that it is proper to credit the interpretation of a dually-qualified physician over the interpretation of a "B" reader. *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (en banc on recon.); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984). *See also Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985) (weighing evidence under Part 718).

I also grant additional probative weight to the x-ray interpretations of Drs. Wheeler, Scott, and Alexander, as each physician examined numerous x-rays and possessed the opportunity to observe the progression, or lack thereof, of the claimant's lung mass. *Cf. Onderko v. Director, OWCP*, 14 B.L.R. 1-2 (1989).

I find that the x-ray evidence, standing alone, is, at best, in equipoise concerning the presence or absence of complicated pneumoconiosis. Six physicians interpreted the claimant's x-rays as negative for complicated pneumoconiosis, while five physicians identified the presence of complicated pneumoconiosis. The probative weight of the evidence shifts slightly toward a finding of no complicated pneumoconiosis when I consider that five dually-qualified physicians interpreted the claimant's x-rays as negative for complicated pneumoconiosis, compared to two dually-qualified physicians identifying complicated pneumoconiosis.

The newly submitted medical opinions also fail to demonstrate complicated pneumoconiosis. Rather, the narrative opinions, like the x-ray interpretations, are in equipoise concerning the presence of complicated pneumoconiosis. Three of the eight physicians addressing the presence of complicated pneumoconiosis – Drs. Smiddy, Robinette, and Alexander – issued narrative medical opinions explicitly diagnosing complicated pneumoconiosis. Drs. Wheeler and Branscomb explicitly opined that complicated pneumoconiosis was not present in the claimant, while Drs. Castle, Michos, and Iosif opined that a positive conclusion of complicated pneumoconiosis could not be made on the available evidence.

Drs. Robinette and Alexander produced well reasoned, probative opinions addressing the presence of complicated pneumoconiosis. Dr. Wheeler's deposition testimony and Dr. Branscomb's narrative opinion are also well reasoned and well documented. Both explicitly conclude that complicated pneumoconiosis is absent.

The opinions of Drs. Castle, Michos, and Iosif are well reasoned and entitled to proba- tive weight, although the three opinions weigh neither for or against a finding of complicated pneumoconiosis. None of the opinions of Drs. Castle, Michos, and Iosif were able to rule in or rule out simple or complicated pneumoconiosis.

I accord Dr. Smiddy's opinion less weight as it is not well reasoned. Dr. Smiddy fails to reconcile his final diagnosis of complicated pneumoconiosis with his previous x-ray interpretations that merely diagnosed simple bilateral pneumoconiosis, which were proceeded by interpretations of the doctor's that diagnosed complicated pneumoconiosis. The doctor's March and September 1998 and January and September 1997 diagnoses of simple pneumoco- niosis followed his May 1995 and April 1996 diagnoses of complicated pneumoconiosis. It is proper to accord little probative value to a physician's opinion which is inconsistent with his or her earlier report or testimony. *Hopton v. U.S. Steel Corp.*, 7 B.L.R. 1-12 (1984) (a failure to explain inconsistencies between two reports which were eight months apart rendered the physician's conclusions of little probative value); *Surma v. Rochester & Pittsburgh Coal Co.*, 6 B.L.R. 1-799 (1984) (physician's report discredited where he found total disability in a earlier report and then, without explanation, found no total disability in a report issued five years later). *See also Brazzale v. Director, OWCP*, 803 F.2d 934 (8th Cir. 1986) (a physi- cian's opinion may be found unrea-soned given inconsistencies in the physician's testimony and other conflicting opinions of record).

Claimant argues that Dr. Smiddy's opinions should receive additional weight due to his status as the claimant's treating physician. (Claimant's Pro Se Statement in Support of Board's Remand, p. 11, citing *Grizzle v. Pickands Mather & Co.*, 994 F.2d 1093, 1097 (4th Cir. 1993)). However, the physician's status alone does not entitle his opinion to greater weight. Rather, it is merely one factor that I *may* consider in my evaluation of the physician's opinion. 20 C.F.R. § 718.104(d) (2000) ("the relationship between the miner and his treating physician *may* constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole). As I find Dr. Smiddy's opinion is poorly reasoned, I accord no additional weight to his opinion due to his status as the claimant's treating physician.

After I evaluate and weigh the probative value of the narrative opinions, I am left with two probative opinions concluding that complicated pneumoconiosis is present, two probative opinions concluding that complicated pneumoconiosis is absent, three opinions that weigh neither for nor against a finding of complicated pneumoconiosis, and an opinion concluding that complicated pneumoconiosis is present to which I accord little probative weight because of its unreasoned analysis.

The determination of whether the claimant has demonstrated a material change in conditions must be made from a review of all of the newly submitted evidence. When I consider all of the newly submitted evidence, I find that the claimant has failed his burden of demonstrating complicated pneumoconiosis by a preponderance of the evidence. Both the x-ray and medical narrative opinions stand in equipoise. As it is Claimant's burden to demonstrate his entitlement to benefits by a preponderance of the evidence and he has failed to do so, I find that his claim must be denied. *Allen v. Mead Corp.*, 22 B.L.R. 1-61 (2000)(holding a claimant must establish, by a preponderance of the evidence developed subsequent to the denial of the prior claim, at least one of the elements of entitlement previously adjudicated against him).

Conclusion

In sum, the evidence establishes neither the existence of complicated pneumoconiosis nor a material change in conditions. Accordingly, the claim of Clarence E. Brown must be denied.

Attorney's Fee

The award of an attorney's fee is permitted only in cases in which the claimant is found to be entitled to benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to claimant for legal services rendered in pursuit of the claim.

ORDER

The claim of Clarence E. Brown for benefits under the Act is denied.

A
JOSEPH E. KANE
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty days from the date of this decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington D.C. 20013-7601. This decision shall be final thirty days after the filing of this decision with the district director unless appeal proceedings are instituted. 20 C.F.R. § 725.479. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2605, Washington, D.C. 20210.